



A Program of the Division of Children, Youth and Families  
Arizona Department of Economic Security

# MEMBER HANDBOOK

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*"Serving Arizona's Children in Foster Care"*



**DES** Arizona Department of  
Economic Security

## CMDP DIRECTORY

**602-351-2245 • Toll Free 1-800-201-1795**

***Listen to phone instructions:***

***Press Option 1 for English, Option 2 for Spanish***

### Extension Numbers:

Member Services .....	Option 3-1*
Medical and Dental Services .....	Option 3-4*
Behavioral Health .....	Option 3-2*
Medical Care Coordinator .....	13665
Provider Services .....	Option 3-3*
Training, Community Relations .....	13627
Grievances, Appeals, Fair Hearings .....	13626
Administration .....	13638

\*These options may change, please follow the phone instructions.

## FAX NUMBERS

Member Services Fax .....	602-264-3801
Medical Services, Dental, Behavioral Health Fax .....	602-351-8529
Provider Services Fax .....	602-264-3801
Claims Fax .....	602-265-2297
Administration Fax .....	602-235-9146

## ADDRESS

### DES/CMDP

Site Code 942C

P.O. Box 29202

Phoenix, Arizona 85038-9202

### WEBSITE ADDRESS

<http://www.azdes.gov/dcyf/cmdpe/>

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## INTRODUCTION

### WHAT IS CMDP?

The Comprehensive Medical and Dental Program (CMDP) is the health plan for Arizona's children in foster care. It was formed in 1970 by state law. Membership is based on state rule and law. CMDP pays for health care services for children placed in and outside of Arizona.

Most CMDP members are eligible for health services covered by the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS is Arizona's Medicaid and KidsCare programs. CMDP becomes the AHCCCS and KidsCare health plan for its members. CMDP provides the same services for all members regardless of AHCCCS eligibility status.

CMDP phone numbers are listed at the top of each page of the handbook. The local phone number is **(602) 351-2245**. For calls from outside of Maricopa County, use the toll free phone number **1-800-201-1795**. The hours of business are 8:00 a.m. to 5:00 p.m., Monday through Friday. CMDP is closed Saturday, Sunday and all state holidays.

The CMDP Member Handbook tells how to get health services. The handbook is directed toward foster caregivers as well as CMDP members. It is printed in English and in Spanish. If you need it in another language or in another format, please call us.

### CULTURAL COMPETENCY

All of us are programmed by our culture. This determines our behaviors and attitudes.

#### **Culture defines:**

- How health care information is received
- How rights and protections are exercised
- What you think is a problem and how symptoms and concerns about the problem are expressed
- Who should provide treatment and the type of treatment

**Culturally Competent Health Care:** Health care services should respect the culture of members. Services are culturally competent when they fit the member. They should be based on the member's needs.

**Benefits of Cultural Competency:** Most people think their own values and customs are best. They may expect other cultures to share those views. Some benefits of having culturally competent health care services are listed below.

For members/foster caregivers:

- Gain sensitivity to member's needs; reduce prejudice and bias
- Improve the quality of member care and outcomes
- Improve member (and foster caregivers) satisfaction
- Develop more appropriate plans of care

CMDP staff and health care providers:

- Work better with diverse patient populations
- Have a better understanding of other cultures in their approach to health care for children
- Comply with federal and state requirements
- Reduce non-compliance of member (and foster caregivers) towards services

We want members to get health care services that are best for them. Please contact Member Services and tell us if any cultural needs are not addressed.

**Member Services as a Resource:** Use the Member Services Unit as a resource for child-specific, culturally competent health care services and/or providers, such as:

- Past AHCCCS health care providers
- A language, gender, ethnic, geographical or specialized health care provider for the individual needs of a member
- Health care services responsive to a member's cultural or religious beliefs
- Translation services for health care appointments
- Interpretation services orally or for hearing impaired
- Health care information in a native language
- Health care information in an alternative format for the visually impaired

### **LANGUAGE AND ORAL INTERPRETATION SERVICES**

If you require CMDP information materials in another format or language, please contact Member Services. There is no charge to members for this service.

CMDP offers the **Language Line Service** for speaking with CMDP and health care providers in a language other than English. The Language Line Service provides translation in over 140 languages by phone, or in writing upon request. The Language Line Service is available free of charge. Call Member Services to use the Language Line Service.

### **MEMBER SERVICES**

Member Services is the main contact point for calls to CMDP. Member Services helps with questions, concerns or problems about health care services.

The Member Services representatives answer questions about:

- Enrollment
- Eligibility
- Member identification cards
- Finding a culturally competent health care provider or pharmacy

### **PROVIDER SERVICES**

The staff in the Provider Services Unit works with health care providers. They register providers with AHCCCS and CMDP. They work to resolve issues concerning providers. The staff works with Member Services to give you the names and locations of registered providers.

## **ELIGIBILITY**

Children are eligible for CMDP when placed into foster care. They do not have to be eligible for AHCCCS or the KidsCare program. Agencies that place children in foster care are:

- Arizona Department of Economic Security (DES)
- Arizona Department of Juvenile Corrections (ADJC)
- Administrative Office of the Court/Juvenile Probation Office (AOC/JPO)

## **DUAL ELIGIBILITY**

AHCCCS members who are eligible for Medicare and Medicaid (AHCCCS) services have dual eligibility. They may be classified as a Qualified Medicare Beneficiary (QMB) or as non-QMB eligible.

QMB-eligible members receive coverage for all Medicaid services including inpatient psychiatric, psychological, respite and chiropractic services.

CMDP members must use health care providers registered with AHCCCS and CMDP. For dual eligible members, Medicare is considered the primary payer and CMDP is the secondary payer. CMDP is responsible for payment of co-insurance or deductibles. CMDP covers the cost of pharmacy co-payments.

## **OTHER INSURANCE**

CMDP is the payer of last resort for members with other health insurance. CMDP coordinates benefits with the other health insurance plan. Deductibles and co-pays are paid by CMDP. The agencies with custody of CMDP members should inform CMDP Member Services in writing what insurance the member has at the time of enrollment.

## **MEDICAL COVERAGE FOR FOSTER CARE YOUNG ADULTS**

Young adults who reach the age of 18 while in out-of-home care may be eligible for the Young Adult Transitional Insurance (YATI) program. The YATI Program is operated by AHCCCS, not CMDP.

To learn more about the YATI program, contact the Arizona Independent Living Coordinator at (480) 545-1901, Ext. 15886. You can also contact your local Family Assistance Administration office for help.

## **ENROLLMENT**

Children are enrolled with CMDP by the agencies that placed them into foster care. When Child Protective Services (CPS) puts a child into a foster care placement, the caregiver should get the form **Notice to Provider, FC-069**.

The form is part of the child's placement packet. It has the member's CMDP identification (ID) number and is used for a temporary ID card. Show the form to health care providers and pharmacies, or give them the CMDP ID number. Use the form until the ID card arrives.

If you do not get this form or an ID number, call CMDP Member Services for help.

### THE IDENTIFICATION (ID) CARD

The ID card is used to assure providers of payment for covered health care services for current members. Show the ID card to pharmacies and health care providers. It has information for billing CMDP for payment.

Two ID cards are made for each member. The ID cards are sent to the agencies with custody of CMDP members. The ID cards are sent after enrollment with CMDP. One of the ID cards is given to the member's caregiver.

The CMDP ID card is only for the member whose name is on the card. It is unlawful and fraudulent to loan or give this card to anyone. Please contact Member Services to request a replacement ID card.

Do **not** use the CMDP ID card to pay for behavioral health prescriptions from the doctors of the Arizona Department of Health Services-Regional Behavioral Health Authority (ADHS-RBHA). The RBHA pays for their prescriptions.

### GENERIC IDENTIFICATION CARDS

CMDP has generic ID cards. Shelters, emergency receiving homes and Child Protective Services offices use these cards. They are only for children not yet enrolled with CMDP.

### NEW MEMBER PACKET

CMDP sends a new member packet to the agency that has custody of the member. The packet is given to the member's foster caregivers.

The packet includes the Member Handbook, the ID card, the CMDP Provider Directory and instructions for selecting a Primary Care Provider (PCP), and related information on CMDP health services.


### CHOOSING A PRIMARY CARE PROVIDER (PCP)

CMDP members should have a Primary Care Provider (PCP). The PCP acts as a personal care doctor. The PCP will provide or arrange for the needed health services.

The PCP works with specialists, pharmacies, hospitals and other providers to track all care a member receives.

To qualify as a PCP, a provider must practice in one of the following areas:

- Pediatrics
- General practice
- Family practice
- General internist

<b>COMPREHENSIVE MEDICAL &amp; DENTAL PROGRAM</b> Arizona Department of Economic Security P.O. Box 29202 (942C) • Phoenix, AZ 85038-9202 (602) 351-2245 • 1-800-201-1795	
Member: _____	_____
DOB: _____	ID#: _____
	Member Helpline: <b>1-800-487-0762</b> Pharmacy Helpline: <b>1-866-453-8230</b>
Do not charge co-pays or any other charges. Bill CMDP.	

- Certified nurse practitioner
- Physician's assistant and supervised by a physician
- Obstetrics and gynecology (OB-GYN) (for pregnant members)

CMDP has a Preferred Provider Network (PPN) to meet the needs of members. The PPN is made up of PCPs, specialists, dentists, pharmacies, hospitals and other health care providers. These providers are listed in the Provider Directory. The directory is available by request, free of charge, through Member Services. The directory is also on the CMDP web site, <http://www.azdes.gov/dcyf/cmdpe/>. The list of providers can be searched by ZIP code and type of provider.

Contact Member Services by phone or mail for assistance in selecting a PCP, or when a PCP has been chosen from the Provider Network. **CMDP must know who the PCP is for each member.** If you need assistance choosing a PCP, ask the staff for help.

### **CHANGING YOUR PRIMARY CARE PROVIDER (PCP)**

When members move, they may need to change providers. If you change PCPs, request to have member medical records transferred from the old PCP to the new PCP. CMDP will work with you to select a new PCP. To request a change, or to notify CMDP of a change, call Member Services.

### **SEEING A SPECIALIST**

A referral from your PCP is needed to see a specialist. Initial evaluations and consultations do not need prior approval (PA). Specialists must get a PA from CMDP before health care services are given. If the services are not approved, a letter is sent stating why and how to appeal that decision.

Female members have direct access to obstetrics and gynecology (OB-GYN) providers; they do not need a referral. Pregnant members may choose their OB-GYN provider as their PCP.

Member Services can give you and the PCP a list of specialists that are registered with CMDP. They are in the **CMDP Provider Directory**. This directory is included in the packet for new members. If you do not have a copy of the Provider Directory, contact Member Services.

## **MEDICAL APPOINTMENTS**

Call the PCP to make an appointment. The phone number is in the Provider Directory and on the PCP letter from CMDP. When you call, tell them the member is covered by CMDP.

**Children must have a full physical exam within the first 30 days of being placed into foster care. Please schedule an exam for members who have not had this exam.**

Ask the CPS Specialist or the juvenile justice representative if the member has any special health care needs. This includes, but is not limited to, pregnancy, chronic asthma and diabetes.

CMDP Medical Services will help locate community support services for the member.

A regular appointment should be scheduled within 21 days of calling a PCP. You should get an urgent (serious, but not life threatening) appointment within two days. You should get an emergency appointment the same day you request it. Call Member Services if you have any trouble getting an appointment.

To cancel or change an appointment, please call providers at least one day before. Some providers may attempt to charge a fee for a missed appointment. By State of Arizona law, CMDP cannot pay for missed or no-show appointments.

Tell the PCP and the CPS Specialist when members get emergency care. It is important for them to know. Ask the PCP which urgent care centers or emergency rooms to use after regular business hours. You can also check the Provider Directory or call Member Services for the approved facilities to use.

## **CMDP COVERED SERVICES**

**Call member services if there are any questions or concerns about covered health care services.**

CMDP pays for health care services that are medically needed. The services include, but are not limited to:

- Doctor office visits
- Well-child check-ups/EPSDT/adolescent screenings and treatment
- Behavioral health services (see Behavioral Health section)
- Hospital services
- Specialist care, as needed
- Family planning services
- Home and community-based services
- Lab and X-ray services
- Pregnancy care
- 24-hour emergency medical care
- Dental care
- Emergency transportation
- Vision care and eyeglasses
- Medically-needed transportation
- Pharmacy services, medical supplies and equipment

## **INCONTINENT BRIEFS**

Incontinent briefs (diapers), including Pull-Ups, may be provided by CMDP if the child needs diapers to:

- Prevent skin breakdown
- Participate in social, community, therapeutic and educational activities

## **These are the CMDP guidelines:**

- The child must be older than 3 years of age
- The child has a documented medical condition that is causing him/her to not have bladder or bowel control
- The PCP has written a prescription for up to 240 diapers per month, unless more is needed depending on the medical condition

- Diapers cannot be provided for bed-wetting only conditions, there must be a documented medical diagnosis
- The CMDP Medical Services Unit will e-mail the CPS Specialist when a diaper request is received and approved
- If CMDP supplies the diapers, the CPS Specialist cannot give the family the stipend that CPS is currently providing toward the purchase of the diapers
- CMDP will have the diapers delivered to the home by a designated supply company

For questions about diaper requests, please contact the Medical Services Unit.

### **PRIOR AUTHORIZATION (PA)**

Services that are not routine need approval in advance from CMDP. It is up to the health care provider to get a Prior Authorization (PA) from CMDP. The PA lets a provider know what services CMDP will cover.

The PA is based on a member's medical needs. A second opinion or more tests may be needed, if in the best interest of the member.

Should CMDP request more information from a provider, it must be sent within 14 days of the request. If CMDP does not get the requested information, the PA request may be denied or delayed. If the request is denied, a Notice of Action letter is sent to the member's CPS Specialist or legal representative on behalf of the member and the provider.

Emergency services do not need a PA from CMDP.

### **WELL-CHILD CHECK-UPS, OR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)**

Well-child check-ups, also known as EPSDT, are for newborns to 21 years of age. The check-ups include medically-necessary services to treat or improve the health of members.

The check-ups should occur according to the AHCCCS Periodicity Schedules listed at the end of this handbook, based on the age of members.

Members should see their PCP regularly so problems can be found early and treated quickly.

CMDP sends medical and dental postcard reminders to foster caregivers. The reminder cards are mailed directly to members that are in the Independent Living Program and living on their own.

The postcards are reminders to see the dentist and to see the PCP for shots and check-ups, depending on the child's age.

Do not wait for members to get sick to seek services. Take advantage of this preventive care program. The services help members stay healthy and grow into healthy adults.

CMDP pays for all well-child check-up exams and screenings. We also pay for any treatments and follow-up services.

Well-child check-ups/EPSDT services include:

- A complete health and developmental history (including physical, nutritional and behavioral health assessments)
- An oral health screening
- A comprehensive unclothed physical exam
- Lead and tuberculosis (TB) screening
- Lab and X-Ray services when needed
- Rehabilitation services which includes occupational, speech and physical therapy, this also includes referrals to Children's Rehabilitative Services (CRS)
- Health education and guidance about the child's health care and development
- Immunizations
- Vision and hearing screenings

If there are questions about EPSDT or well-child services, please call Medical Services, (602) 351-2245 or 1-800-201-1795, Option 3-4.

#### **PARENTS' EVALUATION OF DEVELOPMENTAL STATUS (PEDS)**

It is important that the PCP use the PEDS Developmental Screening Tool for members who were admitted to the Neonatal Intensive Care Unit (NICU) following birth, and for children (up to age 8) who are at risk or identified as having developmental delays. Foster caregivers should ensure that the PEDS screening is used at each EPSDT well-child visit.

#### **BEHAVIORAL HEALTH SERVICES**

AHCCCS and KidsCare-eligible CMDP members get behavioral health services, which include drug and alcohol abuse services, from the Arizona Department of Health Services Regional Behavioral Health Authority (ADHS-RBHA).

The following is a list of the Regional Behavioral Health Authorities (RBHAs):

<b>COUNTY</b>	<b>RBHA</b>	<b>PHONE NUMBER</b>
Maricopa .....	Magellan .....	1-800-564-5465
	Magellan (TTY) .....	602-914-5809
Pima, Cochise, Greenlee, Graham, Santa Cruz .....	CPSA .....	1-800-771-9889
Pinal, Gila, La Paz, Yuma .....	Cenpatico .....	1-866-495-6738
Mohave, Coconino, Apache, Navajo, Yavapai .....	NARBHA .....	1-800-640-2123

In the event of a crisis, call the Crisis Line for the RBHA in your area. If it is a life-threatening emergency, dial **9-1-1**.

**RBHA CRISIS TELEPHONE NUMBERS:**

Magellan .....	602-222-9444
	Magellan TTY ..602-274-3360
CPSA (Pima County) .....	1-800-796-6762
CPSA (Cochise, Greenlee, Graham and Santa Cruz Counties) .....	1-800-586-9161
Cenpatico .....	1-866-496-6735
NARBHA .....	1-877-756-4090

Members can go to the RBHA for an evaluation by self-referral or by referrals from schools, state agencies or other service providers. CMDP covers transportation to the first RBHA evaluation appointment, if the foster caregiver, CPS Specialist, or juvenile justice representative cannot provide it.

Please **do not** use the CMDP ID card to fill prescriptions for behavioral health medications from a **RBHA doctor**. CMDP does not cover the cost for these medications. The RBHA is responsible for payment. Ask the RBHA doctor which pharmacy to use, and give the member's RBHA ID number to the pharmacist.

The RBHA services include, but are not limited to:

- Behavior management (behavioral health personal assistance, family support/home-care training, self/help/peer support)
- Behavioral health care management services (limited)
- Behavioral health nursing services
- Behavioral health residential services (Level 2 and Level 3)
- Behavioral health therapeutic home care services
- Emergency behavioral health care
- Emergency and non/emergency transportation
- Evaluation and assessment
- Individual, group, and family therapy and counseling
- Inpatient hospital services
- Non-hospital inpatient psychiatric facilities (Level 1 residential treatment centers and sub-acute facilities)
- Laboratory and radiology services for psychotropic medication regulation and diagnosis
- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Behavioral health case management services
- Opioid agonist treatment
- Partial care (supervised day program, therapeutic day program, and medical day program)
- Psychosocial rehabilitation (living skills training, health promotion, supportive employment services)

- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Respite care (with limitations)
- Rural substance abuse transitional agency services
- Screening

For members with psychiatric diagnoses, who are **NOT** enrolled with the RBHA, CMDP provides up to 72 hours of inpatient emergency behavioral health services.

Non-Title XIX or Non-Title XXI members may or may not be eligible for behavioral health services through the RBHA, based on funding availability. **CMDP provides behavioral health services to these members. There must be a PA approval from CMDP before services can start.**

A Primary Care Provider can treat a member for mild depression, anxiety, and attention deficit-hyperactivity disorders. The services include prescriptions and medication monitoring visits, laboratory and other tests necessary for diagnosis and treatment of behavioral health disorders. Counseling services are available through the RBHA.

The CPS Specialist or juvenile justice representative should be told that a member needs an evaluation for behavioral health services.

For assistance, contact the CMDP Behavioral Health Coordinators at (602) 351-2245 or 1-800-201-1795, Option 3-2.

## **PRESCRIPTIONS**

When a CMDP provider writes a prescription, it should be filled at a pharmacy that is both registered with AHCCCS and in the CMDP Pharmacy Network. Over-the-counter medications are covered by CMDP when medically necessary. A prescription from the PCP is needed. Use your ID card or the Notice to Provider form for payment.

The major food and retail stores in the CMDP pharmacy management program are listed in the Provider Directory. This includes most pharmacies in Arizona. For help finding a pharmacy, or for any questions about pharmacy services, call Member Services, or go to the CMDP website to view the Provider Directory.

CMDP has a Preferred Medication List (PML). The PML, or formulary, is a list of medications approved by CMDP. Health care providers should refer to the PML when prescribing medications. For medications not on the PML, your provider will need a prior authorization from CMDP *before* you go to the pharmacy.

Not all of the medications on the PML are shown. If you are not able to find your medication on the list please remember the following:

- Most generic medications are approved by CMDP
- CMDP covers all medications when your health care provider demonstrates medical necessity
- Prescriptions written by RBHA providers should be filled *using the RBHA ID number*, not the CMDP ID card
- Formulas are not covered through the PML.

The PML is updated as often as needed to make important changes. The PML can be viewed on the CMDP website at <http://www.azdes.gov/dcyf/cmdpe/>

## **FAMILY PLANNING**

Family planning services are covered for male and female members. CMDP sends a family planning letter to all members age 12 and older. CMDP asks members to talk with their doctors about family planning so good decisions can be made. Family Planning services are available at **no cost** to CMDP members. Family Planning includes, but is not limited to:

- Contraceptive counseling
- Medications
- Supplies (including, but not limited to, oral and injectible contraceptives, diaphragms, condoms, foams, patches, implanted birth control methods, and suppositories)
- Associated medical and laboratory examinations
- Radiological procedures, including ultrasound studies, related to family planning
- Treatment of complications resulting from contraceptive use, including emergency treatment
- Natural family planning education or referral to qualified health professionals
- Postcoital emergency oral contraception within 72 hours after unprotected sexual intercourse

Both male and female members should have yearly exams and lab tests if they are sexually active. Female members do not need a referral from a PCP to see gynecology providers.

CMDP providers educate members on how sexually transmitted diseases (STDs) are passed on to others and how to prevent them. CMDP covers tests for STDs and HIV (the virus that causes AIDS). **HIV testing must have the approval of the member's CPS Specialist or juvenile justice representative, if the member is less than 12 years old. Talk with them if HIV testing is needed. Members 12 years of age and older can self-consent when a doctor states HIV testing is necessary.**

Female members wanting methods of contraception, such as birth control pills, should have a physical exam and lab tests at their first visit, and on a regular basis thereafter.

The following are **not covered** for the purpose of family planning services:

- Infertility services, including diagnostic testing, treatment services or reversal of surgically induced infertility
- Pregnancy termination counseling
- Pregnancy terminations and hysterectomies
- Hysteroscopic tubal sterilization (such as the Essure Micro-Insert)

## **WOMEN'S CARE**

It is very important for sexually active or age-appropriate female members to get a well-woman exam at least once a year to monitor and maintain good physical health. This exam may include, but is not limited to:

- PAP smear test or other cervical screening tests
- Breast exam
- HPV exam

Female members do not need a referral from a PCP to see gynecology providers.

### **PREGNANCY/MATERNITY CARE**

Covered maternity services include, but are not limited to:

- Preconception counseling
- Identification of pregnancy
- HIV testing and counseling
- Prenatal services
- Treatment of pregnancy-related conditions
- Labor and delivery services
- Postpartum care

If a member thinks she is pregnant, make an appointment with the PCP very soon. The PCP will confirm the pregnancy and make a referral to a Primary Care Obstetrician (PCO).

CMDP covers obstetric (OB) services. The PCO specializes in OB care. The PCO monitors and treats pregnant women during pregnancy including delivery and post-partum or after-delivery care. Members should remain with the same PCO for the entire pregnancy. If a member moves or has to change their PCO, every effort is made to ensure there is communication between the PCOs, so there is no interruption in care.

Maternity care coordination for members includes:

- Determining the member's medical /social needs
- Developing a plan of care to meet those needs
- Coordinating referrals to appropriate service providers
- Monitoring to ensure that needed services are received

The PCO will start the member on regular checkups to make sure the pregnancy is going well. Early health care and regular checkups during pregnancy are important to the health of the mother and child.

The standards regarding appointment times for all pregnant members to see their PCO:

- First Trimester (the first 3 months of pregnancy), within 14 days of request
- Second Trimester (the second 3 months of pregnancy), within 7 days of request
- Third Trimester (the last 3 months of pregnancy), within 3 days of request
- High Risk (having special needs that put the mother or the baby at risk of harm), within 3 days of request
- Emergency (when a member has to be seen immediately because of a crisis situation, like bleeding, etc.), immediately

If you have any problems getting an appointment within these timeframes, please contact the Provider Services Unit, (602) 351-2245 or 1-800-201-1795, Option 3-3.

The PCO should tell the CMDP Maternal Health Coordinator (MHC) if there are any special health care needs. The PCO can also ask for a listing of CMDP-registered specialists. It is important for the member to keep all appointments that the PCO schedules.

The MHC explains to the custodial representative the benefits of the member receiving voluntary prenatal HIV testing and counseling. The MHC follows up on the test results to provide counseling or any other services to the member.

CMDP also covers postpartum care services. Postpartum care is the care that is received for up to 60 days after delivery. It includes family planning services and making sure the health of the member is maintained.

**The Medical Care Coordinators** make sure that all needed services are provided to pregnant members. For help, call Medical Services at (602) 351-2245 or 1-800-201-1795 and ask for a Medical Care Coordinator.

CMDP covers pregnancy termination if a pregnant member suffers from any of the following:

- A physical disorder or a physical injury caused by the pregnancy that would place the member in danger of death unless the pregnancy is terminated
- A physical illness which may include a condition that would place the member in danger of death; such as a serious physical or mental health problem, a problem that seriously affects the body's function or any organs or worsens the health problem of the pregnant member, or prevents the pregnant member from receiving treatment for a health problem
- The pregnancy is the result of rape or incest

If the pregnancy is the result of rape or incest, it must be reported to the police. CMDP must be notified and given a copy of the police report. The report must have the name of the agency to which it was reported, and the date the report was filed. The agency with custody of the member knows the procedures to follow.

Authorization from the member, legal representative, a court order **and** CMDP approval are needed, **unless it is an emergency.**

## **COMMUNITY SERVICES**

**WIC** — The special Supplemental Nutrition Program for Women, Infants and Children (WIC) serves to safeguard the health of low-income women, infants and children up to the age of 5 who are at risk nutritionally. WIC provides nutritious foods to supplement diets, information on healthy eating and referrals for health care. WIC provides services to pregnant, breastfeeding or post-partum women. Coverage is 6 months after pregnancy if not breastfeeding, and 1 year if breastfeeding. WIC's toll-free Arizona number is 1-800-252-5942.

**Head Start** — Head Start and Early Head Start are child development programs that serve children from birth to age 5, pregnant women and their families. They have the overall goal of increasing school readiness of young children who are in low-income families. The web site address for more Head Start information is: <http://www.acf.hhs.gov/programs/hsb/>

**AzEIP** — The Arizona Early Intervention Program is a statewide system of programs and services designed to provide support for families of infants and toddlers, ages birth to 3 years old, with

disabilities or delays. The system is designed to help these children reach their full potential. The web site address for information on AzEIP is **<http://www.azdes.gov/azeip/>**

You can also contact the CMDP Medical Services Unit to learn more and for help getting services from these programs.

### **URGENT CARE**

After normal business hours, at night or on weekends, call your PCP to get advice. You may be told to come to the office in the morning or to go to a hospital right away. If you cannot reach the PCP, go to an **urgent care center** if the member's life is not in danger.

Urgent care centers can be used for a cough, sprain, high fever or earache. Urgent care centers have many of the same services as a doctor's office. They can also call **9-1-1** to take a child to the hospital if needed.

Tell the PCP and the CPS Specialist when members receive urgent care. This is important for them to know. You can also check the CMDP Provider Directory or call Member Services for the approved locations.

### **EMERGENCY CARE**

Emergencies are medical problems that may be life threatening if not treated quickly. Examples of emergencies are major bleeding, broken bones, breathing difficulties, seizures, and unconsciousness.

In a true medical emergency, the well-being of the member is most important. Please dial **9-1-1** or go to the nearest hospital emergency room. Show the CMDP ID card to pay for any services.

***A hospital emergency room is not to take the place of a doctor's office. Do not use it for minor medical problems.***

Tell the PCP and the CPS Specialist when members receive emergency care. This is important for them to know. You can also check the CMDP Provider Directory or call Member Services for the approved locations.

### **EMERGENCY TRANSPORTATION**

Dial **9-1-1** or contact the local ambulance service for transportation in a life-threatening emergency situation. This service is covered by CMDP.

### **MEDICALLY-NEEDED TRANSPORTATION**

Foster caregivers should take members to their scheduled appointments. Help can be sought from the CPS Specialist or juvenile justice representative. If they cannot help, contact Member Services to provide transportation. Arrangements for non-emergent transportation must be made at least 24 hours in advance of the appointment.

### **DENTAL CARE**

An oral health screening should be part of an EPSDT screening done by a PCP. It does not take the place of an exam through a direct referral to a dentist. Members do not need a referral from their PCP and can see any dentist listed in the Provider Directory.

The American Academy of Pediatric Dentistry recommends dental visits begin by the age of **one year old**. All members by the age of three should see the dentist **twice a year for routine exams, and more often if needed**.

Routine dental services are covered by CMDP. A dentist needs approval in advance (PA) for major dental services.

The following is a list of covered dental services:

- Dental exams and X-rays
- Treatment for pain, infection, swelling and dental injuries
- Cleanings and fluoride treatments
- Dental sealants
- Fillings, extractions and medically-necessary crowns
- Pulp therapy and root canals
- Dental education

#### **VISION CARE**

Vision care services include:

- Eye exams
- Eyeglasses and bifocals
- Scratch coating
- Repairs and replacement of eyeglasses
- Tinted lenses (when medically needed)
- Contact lenses (with a statement of why they are medically needed)

#### **SERVICES NOT INCLUDED**

Listed below are examples of services CMDP does not cover:

- Any care that is not medically needed
- Any hospital admission, service or item that needed prior authorization (PA) but was not approved in advance or was denied
- Services or items for cosmetic purposes; services needed for the psychological well-being of the member need a PA
- Services or items that are free of charge or for which charges are not usually made
- Abortion, unless prior approved and abortion counseling
- Personal care items such as shampoo, mouthwash, and diapers for members newborn to three years old
- Dietary formulas or diet supplements (unless they are the only source of nutrition and/or medically necessary)
- Medical services to an inmate of a public institution, such as a jail or correction facility
- Care provided by individuals who are not properly licensed or certified and who are not CMDP registered

## **TIPS FOR TRAVELERS**

When traveling, always bring the CMDP ID card. Contact Member Services for help (use the toll free phone number, 1-800-201-1795). Even if providers are not registered with CMDP, present the ID card and tell them to bill CMDP. The billing address is on the card.

Have all prescriptions filled before leaving home. You should have enough medications for the trip or vacation. If you need a pharmacy, use one under contract to CMDP.

If you do not find a pharmacy or a health care provider that is willing to bill CMDP, keep all receipts and bills. Contact Member Services to get instructions for a full refund after your trip.

## **OUT-OF-AREA MOVES**

Contact Member Services when you move with a CMDP member from one area, county or to another state. CMDP needs to know the new address for the member. The CPS Specialist and the PCP should also be contacted.

Advance notice to the PCP allows time for the transfer of medical files to a new health care provider or PCP. This ensures continuity of care for the member.

If you move with a member to another state, contact the CPS Specialist for assistance in getting health care services in the new state. The foster caregiver should give CMDP and the CPS Specialist the new address of the member.

The CPS Specialist must tell the new state about the plans to provide health care services for the member. The CPS Specialist will find out if the member can get Medicaid services in the new state. If so, the foster caregiver is informed how to apply for Medicaid services.

If the member is not eligible, CMDP covers all medically necessary health care services. Provider Services and Member Services Units work with the CPS Specialist to locate and register health care providers.

Contact Member Services if you need help finding a pharmacy for the member. If you have problems filling your medications contact Medical Services for help.

## **DO FOSTER CAREGIVERS PAY ANYTHING?**

There are no payments, fees, or co-payments for members or their foster caregivers. Members and foster caregivers should not be billed for any services that CMDP covers. CMDP payments are considered payment in full. Do not agree to pay for any services unless you have spoken to CMDP first or it is an emergency.

**CMDP should be listed as the responsible party. Do not list your home address, phone number or Social Security number on any bills or claims.**

If you have to sign any forms, please write all of this information shown below:

***(Foster Caregiver's name) for DES/CMDP***

***Send all bills or claims to: DES/CMDP—942C; P.O. Box 29202, Phoenix, AZ 85038-9202***

**PLEASE NOTE:** When the PCP writes a prescription for a brand name medication and a generic medication is available, CMDP covers the cost of the generic. If the foster caregiver insists on the brand name when a generic is available, the foster caregiver is financially responsible for the difference in cost between the generic and the brand name medications. If the PCP receives prior authorization (PA) from CMDP for the brand name and writes the prescription “fill as prescribed”, or there is no generic for that medication, CMDP will cover the cost of the brand name.

## **WHAT EVERY MEMBER SHOULD KNOW**

### **MEMBER RIGHTS**

For members to receive the health care services they need and deserve, members and foster caregivers should be aware of the following rights:

- The right to be treated with respect, and recognition of the member’s dignity and need for privacy (This right includes protection of any information that identifies a particular member)
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as stated in other Federal regulations on the use of restraints and seclusion
- The right to not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment
- The right to have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as members with visual or auditory limitations
- The right to have the opportunity to choose a primary care provider and choose other providers as needed from among those affiliated with the network
- The right to obtain, at no charge, a directory of health care providers in the PPN
- The right to receive information on available treatment options and alternatives, in a manner appropriate to the member’s condition and ability to understand
- The right to have a second opinion from a qualified health care professional within the PPN or have a second opinion arranged outside the PPN, only if there is not adequate in-network coverage, at no cost to the member
- The right to participate in decision-making regarding their health care in the present and the future, and to have a representative to facilitate care or treatment decisions when the member is unable to do so (For more information on “Advance Directives” and life care planning, please contact Member Services or see the State of Arizona Attorney General’s website <http://www.azag.gov/seniors>. Look under “Seniors” or “Consumers” for Life Care Planning Information)
- The right to be provided with information, in a language the member understands, about the amount, duration and scope of all services and benefits, service providers, services included and excluded as a condition of enrollment, and other information including:
  - Provisions for after-hours and emergency health care services
  - Information about available treatment options or alternative courses of care

- The right to refuse treatment or to receive no treatment, **in accordance with applicable federal and state laws**
  - Procedures for obtaining AHCCCS-covered services that are not offered or available through CMDP, and notice of the right to obtain family planning services from an appropriate AHCCCS registered provider
  - The right to use any hospital or settings for emergency care
  - The right to know about providers who speak languages other than English
  - The right to be provided with information regarding how to submit a grievance, appeal or request a hearing about CMDP or the care provided
  - How to obtain prompt resolution of issues they have raised, including grievances and issues related to the authorization, coverage, or payment of services
  - The right to confidentiality of health and medical records and other member information
  - The right to request and receive a copy of their medical records in accordance with applicable Federal and State laws at no cost
- (The right to access medical records may be denied if the information is psychotherapy notes, compiled for, or in reasonable anticipation of a civil, criminal or administrative action, protected health information subject to the Federal Clinical Laboratory Improvement Amendments of 1988 or exempt pursuant to 42 CFR 493.3.)
- The right to amend or correct medical records (as specified in 45 CFR 164.526)
  - The right to be informed of a description of circumstances whereby, for legitimate cause, a copy of a record may be denied, even though the record may be reviewed
  - The right to a listing of types and locations of records maintained and the title of the official(s) responsible for such records
  - The right to request information regarding if CMDP has physician incentive plans that affect referrals from doctors
  - The right to know about the type of compensation arrangements with providers, whether stop-loss insurance is required of providers and the right to review member survey results
  - The right to contact Member Services if there are any questions regarding member rights
  - The right to have a description of how CMDP evaluates new technology for inclusion as a covered benefit

## **MEMBER AND FOSTER CAREGIVER RESPONSIBILITIES**

Members and foster caregivers are responsible for:

- Providing as much information as possible to professional staff working with the member
- Following prescribed treatment instructions and guidelines given by those providing health care
- Knowing the name of the member's PCP or doctor
- Scheduling appointments with the doctor during office hours whenever possible, before using urgent care or a hospital emergency room
- Taking the member to medical appointments. Contact the assigned worker or CMDP if you cannot provide transportation

- Arriving at appointments on time
- Notifying the provider at least one day in advance when unable to keep an appointment
- Carrying the CMDP ID card (or Notice to Provider form, if the card has not arrived) at all times, and presenting it to the health care provider
- Bringing all available shot records and medical history information to the doctor or PCP
- Taking the member for well-child checkups
- Taking the member for a dental exam at least twice a year
- Using Children's Rehabilitative Services when asked to do so by CMDP or the PCP
- Working with CMDP, the CPS Specialist and the PCP to make certain the member is receiving the best care possible
- Ensuring that each member has all childhood and teenage immunizations (shots) appropriate to the child's age and health
- Always listing DES/CMDP as the responsible party, and the CMDP address for billing. **(CMDP - 942C, P.O. Box 29202, Phoenix, AZ 85038-9202)**

**SERVICES FOSTER CAREGIVERS CANNOT AUTHORIZE:**

- General anesthesia
- HIV testing, if the member is under age 12 (members over age 12 can self-consent)
- Blood transfusions
- Abortions
- Any surgery or medical treatment that is not routine

**MAINTAINING GOOD HEALTH**

Suggestions to help keep members healthy:

- Make sure all members have an immunization record and shots are up-to-date
- Follow up on all referrals made during visits with the Primary Care Provider (PCP), including those for dental, vision care and therapies
- Members should wear proper fitting shoes to prevent injury or infection
- Keep fingers and toenails clean to prevent injury and infection
- Make sure all medical records go to a new doctor or PCP and a new CPS Specialist
- Caregivers, along with the PCP, should discuss birth control, safe sex and prevention of sexually transmitted diseases and HIV with young adult members
- Take pregnant members to all prenatal care appointments and make sure all post partum doctor visits are kept after the baby is delivered

**HIPAA NOTICE**

The Health Insurance Portability and Accountability Act (HIPAA) affects health care in several ways.

CMDP is required to have safeguards for protecting members' health information. This applies to all health care providers and other stakeholders.

A member's protected health information (PHI) may be used for treatment, payment and health plan operations and as permitted by law. The member or the legal guardian must give written approval for any non-health care uses of PHI.

CMDP provides a notice of members' rights and responsibilities on the use, disclosure and access to PHI. It is called the "Notice of Privacy Practices" (NPP). The NPP is sent to the legal guardians of CMDP members. It is also included in the New Member Packets. Anyone can request the NPP by calling the CMDP **Privacy Officer** or downloading it from <http://www.azdes.gov/hipaa/>

The CMDP **Privacy Officer** explains the NPP and answers questions about HIPAA. Call (602) 351-2245 or 1-800-201-1795 ext. 13626.

### **FRAUD AND ABUSE**

**Fraud** is defined by CMDP as an intentional act made with the knowledge that it could result in some unauthorized benefit.

**Abuse** is defined as the action of a provider that does not meet sound business or medical practices. The result is unneeded cost to CMDP for services that are not medically necessary.

Loaning, giving or selling CMDP ID cards to others are examples of fraud or abuse. If you suspect fraud or abuse, please report it to Member Services.

The CMDP Fraud and Abuse Coordinator reviews and refers incidents of potential fraud and abuse to the AHCCCSA Office of Program Integrity (OPI). Members and foster caregivers have the option of referring potential incidents to the OPI directly at 602-417-4193 or 1-888-487-6686.

### **GRIEVANCES AND APPEALS**

A **grievance** is a complaint, which means an expression of dissatisfaction about any matter other than an action. Grievances include, but are not limited to, the quality of care or services provided, rudeness of a provider or employee, or failure to have a member's rights respected.

A member or an authorized representative (the CPS Specialist or juvenile justice representative) can file a grievance. A provider can file a grievance on the member's behalf, but **only** with the written consent of the member's authorized representative.

A grievance can be filed at any time either orally or in writing to CMDP. A disposition will be completed and provided no later than 90 days after the day CMDP received the grievance. A grievance resolution/response cannot be appealed or be the subject of a hearing.

A "**Notice of Action**" is a response from CMDP regarding a requested service. If a member disagrees with the Notice of Action response, the member or an authorized representative can file an appeal. An action documented on the Notice of Action by CMDP includes, but is not limited to the following:

- The denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service

- Failure to provide a service in a timely manner (as set forth in contract)
- Failure of CMDP to act within the time frames specified
- For a member residing in a rural area, denial of your rights to obtain services outside the network

An **appeal** is a request for review of an action as listed above. Appeals can be filed either orally or in writing within 60 days after the date of the “Notice of Action.” Information on how to file an appeal is given with the denial, reduction, suspension or termination of service notice, or the “Notice of Action” form. (Call the Grievance Coordinator at (602) 351-2245 or 1-800-201-1795, Ext. 13626 if you have any questions or need more information.)

CMDP makes a final decision on appeals within 30 days of receiving a written or an oral appeal. A letter will be mailed to the *appellant* (whomever filed the appeal), stating CMDP’s decision and the reason for the decision.

If the member feels that their life or health could be in danger by waiting 30 days the member or authorized representative can request an **expedited appeal**.

An expedited appeal is a faster review. A decision on an expedited appeal is provided within 3 working days as opposed to the normal 30 days. The member’s health care provider **must** provide documentation to support the request for an expedited appeal.

If the member or authorized representative disagrees with a decision that CMDP has made on an appeal, a State Fair Hearing can be requested.

The member or authorized representative can request a State Fair Hearing by writing CMDP no later than 30 days after receiving the appeal decision. CMDP will forward the case file and information to the AHCCCS Office of Administrative Legal Services (OALS). If the member or authorized representative has questions or needs more information regarding a State Fair Hearing contact the Grievance Coordinator at (602) 351-2245 or 1-800-201-1795, Ext. 13626.

The member or authorized representative may request continuation of services while the appeal is pending. The services will continue if:

- The appeal is filed timely
- The appeal involves the termination, suspension or reduction of previously authorized services
- Services were authorized by CMDP
- Original period covered by original authorization has not expired
- The member requests and CMDP approves that services continue

Requests for continuation must be filed within 10 days after the date CMDP mailed the “Notice of Action” or the effective date of the action as indicated in the “Notice of Action.”

**BEHAVIORAL HEALTH GRIEVANCES**

If there is a concern about the behavioral health services the member is receiving, contact the CPS Specialist, juvenile justice representative or a CMDP Behavioral Health Coordinator to determine if the services are being provided through CMDP or the Arizona Department of Health Services - Regional Behavioral Health Authority (ADHS-RBHA).

If the member is receiving services that CMDP is responsible for, the CMDP Behavioral Health Coordinator will help you contact the CMDP Grievance Coordinator to resolve your grievance. Call the Behavioral Health Coordinators at (602) 351-2245 or 1-800-201-1795, Option 3-2.

If the member is receiving services for which the RBHA is responsible, contact the patient representative at the RBHA.

If the problem cannot be resolved to your satisfaction, you have a right to involve the CPS Specialist or juvenile justice representative to file an appeal with the RBHA.

**CMDP CORPORATE COMPLIANCE**

The Corporate Compliance Program formalizes and affirms CMDP's commitment to the legal and ethical behavior of our employees. The CMDP Code of Conduct cannot cover every situation, or substitute for common sense, individual judgment and personal integrity. It is the duty of each CMDP employee to follow these principles:

- Respect the rights, dignity and diversity of each individual
- Maintain the appropriate levels of confidentiality for information and documents
- Comply with all applicable laws
- Conduct CMDP affairs in accordance with the highest ethical standards
- Ensure proper payment for services
- Avoid conflicts of interest
- Provide a safe working environment
- Provide equal opportunity to each employee
- Promote open communication
- Conduct all business with honesty and integrity

**CORPORATE COMPLIANCE HOTLINE**

The CMDP Corporate Compliance Hotline is the confidential voice mailbox of the CMDP Compliance Officer. It is available 24 hours a day, 7 days a week. Anyone can use this resource to report, in good faith, concerns involving CMDP employees and potential fraud, unethical, illegal or unacceptable practices or compliance violations.

All calls are kept confidential to the extent permitted by law. Although the caller is encouraged to identify him or herself, the call can be an anonymous report. The CMDP Compliance Officer will investigate all reports of improper conduct, and take action equitably and consistently.

Reports can be made by calling the CMDP Corporate Compliance Officer at (602) 771-3555.

## RECOMMENDED IMMUNIZATION SCHEDULES

The State of Arizona has laws requiring school children and childcare enrollees to be age-appropriately immunized. The exceptions and additions to the rules are as follows: Biological parents whose religious beliefs do not allow immunizations must sign a religious exemption; the child's doctor must sign a medical exemption form if there is evidence of immunity or a medical reason why the child cannot receive shots. A copy of the lab results must be kept on file to prove the child's immunity.

Vaccine reactions rarely happen and usually are no worse than minor flu symptoms. Serious reactions are very rare. The dangers of not being immunized are far worse than the possibility of serious reaction.

### PRE-TEEN VACCINES

As children get older, protection given by some childhood vaccines may wear off. Children can also develop risks for more diseases. Help your child by staying up-to-date on pre-teen vaccines. Doctors recommend that all children ages 11 -12 get the Tdap and meningitis vaccines. Girls ages 11-12 should get the human papillomavirus (HPV) vaccine. Please be sure pre-teens have 2 MMR shots.

Call the EPSDT Coordinator at (602) 351-2245 or 800-201-1795 if you need, or would like, a lifetime immunization card to keep track of all the immunizations your foster child receives.

**Note:** The recommended immunization schedule is periodically changed by the Centers for Disease Control and Prevention. Discuss your foster child's immunizations with your child's PCP or doctor.

### RECOMMENDED IMMUNIZATION SCHEDULE FOR PERSONS AGE 0—6 YEARS

Vaccines are listed under the routinely recommended ages. **[BARS]** indicate range of recommended ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization on any subsequent visit when indicated and feasible.

**[SHADED BOXES]** indicate age groups that warrant special effort to administer those vaccines not previously given. **[DASHED BOXES]** indicate vaccines for certain high-risk groups.

AGE → VACCINE ↓	BIRTH	1 mo.	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.	18 mos.	19-23 mos.	2-3 yrs.	4-6 yrs.
Hepatitis B	HepB	HepB	HepB*	HepB*	HepB	HepB	HepB	HepB	HepB Series		
Rotavirus			Rota	Rota	Rota						
Diphtheria, Tetanus,			DTaP	DTaP	DTaP		DTaP				DTaP
H. influenzae Type b			Hib	Hib	Hib*	Hib		Hib			
Pneumococcal			PCV	PCV	PCV	PCV				PCV PPV†	
Inactivated Polio			IPV	IPV	IPV	IPV					IPV
Influenza						Influenza (yearly)					
Measles, Mumps,						MMR					MMR
Varicella						Varicella					Varicella
Hepatitis A						HepA (2 doses)				HepA Series	
Meningococcal										MCV4	

As of December 1, 2007

\*Hepatitis B (HepB) at 4 months and Influenza Type B (Hib) at 6 months are optional doses. Discuss these options with your child's physician.

†Pneumococcal polysaccharide vaccine (PPV) is recommended in addition to PCV for certain high risk groups.

Approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

### RECOMMENDED IMMUNIZATION SCHEDULE FOR PERSONS AGE 7-18 YEARS

Vaccines are listed under the routinely recommended ages. **[BARS]** indicate range of recommended ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization on any subsequent visit when indicated and feasible.

**[SHADED BOXES]** indicate age groups that warrant special effort to administer those vaccines not previously given. **[DASHED BOXES]** indicate vaccines for certain high-risk groups.

AGE → VACCINE ↓	7-10 Yrs.	11 - 12 Yrs.	13 - 14 Yrs.	15 Yrs.	16 - 18 Yrs.
Tetanus, Diphtheria, Pertussis	See note 1	Tdap		Tdap	
Human Papillomavirus	See note 2	HPV (3 doses)		HPV Series	
Meningococcal	MCV4	MCV4		MCV4	MCV4
Pneumococcal	PPV				
Influenza	Influenza (yearly)				
Hepatitis A	HepA Series				
Hepatitis B	HepB Series				
Inactivated Polio	IPV Series				
Measles, Mumps, Rubella	MMR Series				
Varicella	Varicella Series				

As of December 1, 2007

<sup>1</sup>Tdap administered at 11-12 years for those who completed the childhood DTaP series, or at 13-18 years if the booster dose was missed.

<sup>2</sup>Administered to females at 11 - 12 years, in three doses, with subsequent two and six months after first dose.

Approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).



SISTEMA DE CONTENCIÓN DE COSTOS MÉDICOS EN ARIZONA  
TABLA DE PERIODICIDAD EPSDT

PROCEDIMIENTOS	Infancia						Niñez temprana				Niñez tardía				Adolescencia							
	Recién nacido	2-4 días	para 1 meses	2 meses	4 meses	6 meses	9 meses	12 meses	15 meses	18 meses	24 meses	3 años	4 años	5 años	6 años	8 años	10 años	12 años	14 años	16 años	18 años	20 + más hasta 21 años
Historia inicial/Periódica	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Estatura y peso	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Circunferencia de la cabeza	X	X	X	X	X	X	X	X	X	X	X											
Presión sanguínea												X	X	X	X	X	X	X	X	X	X	X
Evaluación de la nutrición	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Visión**																						
Oído**/Habla																						
Evaluación del desarrollo/conducta	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Examen físico	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Immunización	X —▶	▶	X	X	X	X		◀	X	▶			◀	X	▶		◀	X	▶	▶		
Prueba de tuberculina								+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Hematocrito/hemoglobina		◀					X										◀		X			▶
Análisis de la orina																	◀		X			▶
Examen por plomo								X			X	*	◀	▶								
Guía previsora	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Recomendación dental**																						

Estos son requisitos mínimos. Si en algún momento surge la necesidad médica de realizar otros procedimientos, pruebas, etc., el médico tiene la obligación de hacerlos. Si un niño inicia su cuidado médico en cualquier punto de esta tabla, o si algunos procedimientos no se han realizado para la edad recomendada, deberán realizarse lo antes posible.

\* Los miembros dentro de esta gama (entre 36 y 72 meses de edad) que no han sido evaluados deberán someterse a un examen de la sangre por plomo.

\*\* Vea la tabla separada para detalles.

**Clave:** X Por hacer

+ A hacerse a miembros que están a riesgo.

◀X→ Las edades durante las cuales se puede ofrecer un servicio, con la edad preferida indicada por X.

\*\* Vea la tabla separada para detalles.

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**
**VISION PERIODICITY SCHEDULE**

PROCEDURE	MONTHS												YEARS											
	New born	2-4 days	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3* yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20 + up to 21 yr		
Vision + + +	S	S	S	S	S	S	S	S	S	S	S	O	O	O	S	S	O	O	S	S	O	S		

These are minimum requirements. If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key: S Subjective, by history.  
O Objective, by a standard testing method.  
\* If patient is uncooperative, rescreen in six months.  
+++ May be done more frequently if indicated or at increased risk.

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**
**HEARING AND SPEECH PERIODICITY SCHEDULE**

PROCEDURE	MONTHS												YEARS											
	New born	2-4 days	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3* yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20 + up to 21 yr		
Hearing/Speech + + +	S/O	S	S	S	S	S	S	S	S	S	S	O	O	O	S	S	O	O	S	S	O	S		

These are minimum requirements. If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key: S Subjective, by history.  
O Objective, by a standard testing method.  
\* All children, including newborns, meeting risk criteria for hearing loss should be objectively screened.  
+++ May be done more frequently if indicated or at increased risk.

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**
**DENTAL PERIODICITY SCHEDULE**

PROCEDURE	MONTHS	YEARS																	
	Birth thru 36 months	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20 + up to 21 yr
Dental Referral	+	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Referrals for routine dental visits should begin at age three (3). Earlier initial dental evaluations may be appropriate for some children. Subsequent evaluations as prescribed by dentist.

Key: + Birth to 36 months if indicated  
X To be completed

**NOTES**


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